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Abstract

This paper examines the current range of housing options available to HIV/AIDS infected persons and estimates how well the Canadian housing system satisfies needs. Five constituencies are examined in a cross Canada investigation: gay men, women, haemophiliacs, injection drug users, and sex trade workers. In all populations, there was little difference in the elasticity of demand for adequate and accessible housing. Persons with HIV cannot exchange quality of accommodation and proximity to health and social services for lower prices (rents) without severely compromising health status. The problem of securing appropriate housing for persons with HIV will be resolved only by changing elements of Canada's housing system. A housing options model and a model of intervention to achieve a range of appropriate housing options are described. The relatively high status of HIV/AIDS on the public agenda is cause for some optimism that the political will for change will be generated.

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Housing for Persons with HIV Infection in Canada:

Issues, Options and Housing System Impacts

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In any culture, housing is much more than a physical structure. It locates one in the community and gives a sense of place and belonging. It is a basic element in ensuring safety and security. It is an anchor from which all aspects of daily life, including community and social services, are accessed and received. The housing requirements imposed by HIV infection and the societal response to persons who are infected, interact to affect the housing issues and options for persons who are HIV positive. All of these relationships occur against the backdrop of the nature of the existing housing stock and housing policy.

All people require housing appropriate to their needs. To obtain appropriate housing, the operation of a nation's housing system must provide residential dwellings which are adequate, accessible, affordable, and available. If it does, then people can be appropriately housed.

Appropriate housing for persons with HIV in Canada is considered here from the perspectives of issues relating to the individual, the community, the private sector and the state (government and its agencies at all levels). This paper is based on a national study of housing options for persons with HIV infection in Canada funded by National Welfare Grants, Health and Welfare Canada. The study method included analysis of seroprevalence rates of HIV and AIDS, housing market data, and face-to-face interviews with over 150 persons representing formal and informal organizations related to persons with HIV and persons living with HIV/AIDS. The picture that results is one of very limited choice for persons with HIV infection in Canada's housing system.

1. The Housing System and Social Change

Housing policy analysis must be rooted in and must ask questions about the housing system. The housing system refers to the ways in which a physical stock of buildings used as shelter are produced, allocated and maintained in any society. Over time a set of housing "rules of the game" evolves, specifying: how land is owned, sold, taxed, and regulated; how finance capital is allocated to the residential sector and at what interest rates; how houses are built and who builds them; and how houses are allocated and how they change hands.

All societies need to develop a method -- the rules -- for producing and distributing the required housing and for creating desirable "groupings" of houses, the neighbourhoods and communities. These "rules" are not static, but are continually evolving, affecting who gets what out of the housing system, at what location, and under what conditions. The housing policy of a government is implemented through a blend of methods, including regulation, direct expenditures, tax expenditures, taxation, and public ownership. Since housing is an essential element in the quality of life of all individuals, the major role played by housing policy makes it one of the more important modes of social change.

How does housing policy change a country's housing system? Unmet needs must rise high enough on the public agenda to lead to the formulation of and debate over potential solutions. Implementation of an appropriate and effective policy measure can lead to significant change in the housing situation of a particular group.

One of the most recent new categories of housing need relates to the housing situation of persons with HIV infection. It is estimated that 30,000 to 50,000 Canadians are HIV infected.[1] There have been 2,800 known deaths from AIDS and 1,880 persons are known to have AIDS.[2] The HIV population in Canada consists primarily of groups who are already the target of discrimination in the housing sector and are often inadequately housed before HIV diagnosis: gay males, injection drug users, women, sex-trade workers, and street people. Becoming HIV positive adds another layer of discrimination. Unless a house is owned with the mortgage paid off, being HIV positive can often mean losing one's job and becoming unable to meet mortgage or rent payments. In addition, the specialized services for HIV infected people are concentrated in the heart of the larger cities, where housing costs are the highest.

What we find in terms of housing policy and potential change to the housing system in the case of HIV infection is a category of need which (1) has a high public profile and (2) involves a broad range of deficiencies in the housing system. These include: continually low vacancy rates (often below 1%) in the rental markets of the larger metropolitan areas; long waiting lists in the small non-market social housing sector; inadequate welfare and disability income support and rent allowance payments; human rights legislation and enforcement measures which fail to protect people from

discrimination in housing; and a lack of housing units appropriate to people with physical disabilities located near the required medical and social services. Many Canadians already face one or more of these problems. Many persons with the HIV infection, especially those who have developed AIDS, face all of them. The high public profile of the infection is yet another factor in helping to focus additional pressure for changes to the housing system to alleviate these problems.

2. Canada's Housing System: What is the Problem?

Canada's 9.5 million households, on average, are well housed compared to most countries. Sixty percent own their own homes and half these owners have no mortgage. More than half of Canada's housing stock (56%) is in the form of single detached houses with another 9% in single attached (duplex) houses. Many Canadians, therefore, live at relatively low densities, even though 75% of the population is urban.[3]

With the adoption of the Dominion Housing Act in 1935 the Canadian government initiated a permanent role for itself in Canada's housing sector.[4] There have been numerous programs for home ownership and for the private rental sector ever since.[5] Yet any analysis of housing conditions finds that the housing situation for at least some Canadians is not getting better, and for others, the homeless, inner city poor, and native Canadians, for example, conditions are much worse.

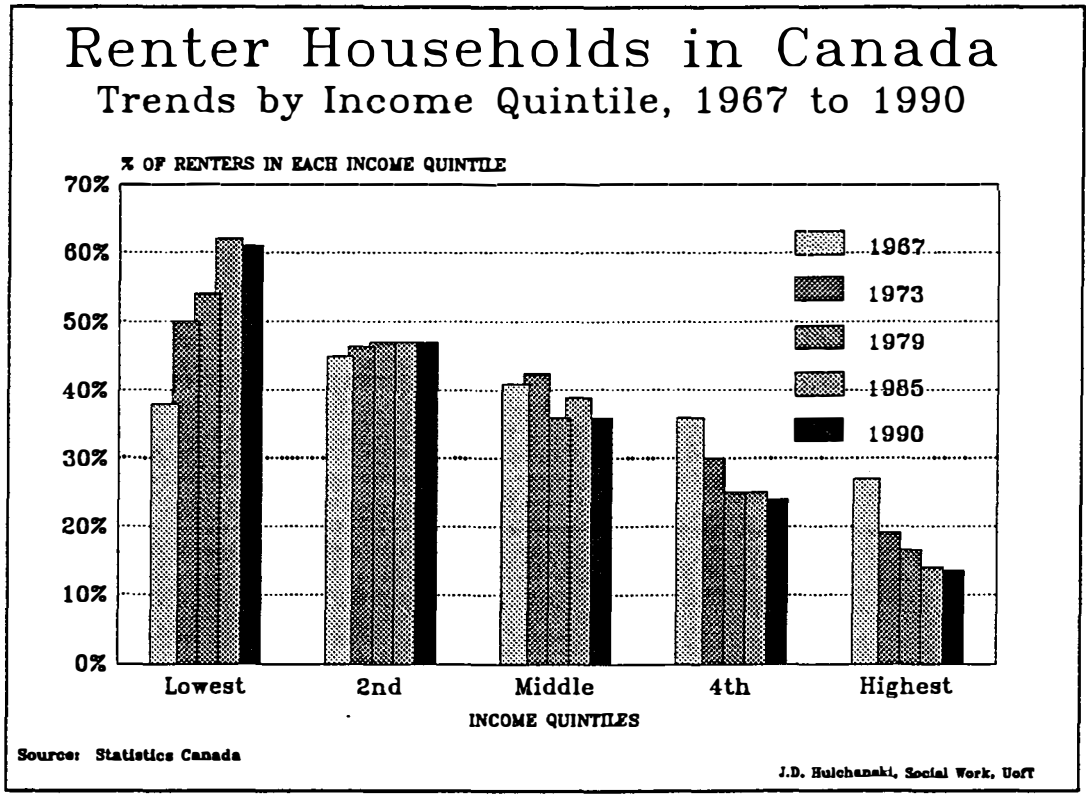
Why are there still serious housing problems after more than fifty five years of government housing programs? Virtually all the more serious elements of Canada's housing problem relates to the fact that Canada has an *incomplete* housing system. As the housing system evolved in the post-war years, no provision was made for ensuring that there would be adequate rental housing supply. It was assumed that the market would be adequate and it was further assumed that lower income households would obtain their housing by down filtering of units. To some degree this was true in the 1950s and 1960s. Filtering down of older units in the inner city supplied poor quality affordable housing to the poor.

It is when we look at renter households and the rental market in Canada that we find serious problems. Though forty percent of households are renters, they are concentrated in cities, especially the largest cities. Over 60% of the households in the cities of Montreal, Toronto and Vancouver are renters and many are very poor. According to the most recent estimates, 37% of all renter households in Canada live in poverty. This is 1.28 million households out of Canada's 3.5 million renter households.[6]

Canada does not have a *complete* housing system. The home ownership sector works -- all one needs is lots of money and a secure job -- the rental sector does not. The housing challenge of the 1990s is developing a rental housing supply, allocation and maintenance system which works. It is a major challenge for two key reasons. First, only five percent

of the housing stock is non-market housing, *i.e.*, various forms of subsidized public and non-profit housing. Most of these units are of relatively good quality but the waiting lists are very long. The second reason the rental sector is in serious trouble is due to the polarization of the population by income and tenure. As Figure 1 indicates, in just over twenty years, there has been a dramatic shift in the composition of the renter population. Relatively few renters are now drawn from the top two quintiles. Soon virtually all renters will be drawn from the bottom range of the income scale.

FIGURE 1



The problem with the private rental sector is that this demand for rental housing is not effective market demand. The people who need adequate, affordable rental housing appropriate to their needs do not have the money to pay for it. These households generate social *need*, not market demand; the market responds to market demand, not social need. Yet Canada relies on the private market for the supply and maintenance of most of its rental housing stock. Renters, unlike home owners, cannot obtain housing appropriate to their needs at a price they can afford. Demand in the home ownership sector is being met; demand in the rental sector is not. Even worse, good quality affordable rental stock is continually being lost to demolition and condominium conversion. The private rental sector cannot meet their housing needs, yet Canada has an extremely small stock of non-market housing.

Persons with HIV who have little or no income must cope with their health problems and with Canada's incomplete housing system. If they do not already have a secure place in the housing system before their HIV infection develops into AIDS, they will certainly face a severe problem finding appropriate housing -- housing which is adequate, accessible, affordable and available.

3. HIV Infection: Health Status and Psycho-social Issues

Physical Characteristics. HIV is a communicable disease that is transmitted through bodily fluids -- semen, blood and breast milk. Sexual intercourse and sharing needles with an infected person are the primary forms of transmission. Blood transfusions that took place before 1985 were responsible for infecting 943 people in Canada.[7] The majority are in the hemophiliac group. Deep needle sticks are rare, generally experienced only by health professionals and the probability of contracting HIV from a needle stick is much less probable than, for example, hepatitis.[8]

Without laboratory testing at the asymptomatic stage, knowledge of one's own HIV infection or identifying the presence of the virus in others is very uncommon. Individuals who carry HIV may remain asymptomatic for several years before displaying any of the signs of AIDS, and may only learn of their diagnosis when symptoms typical of AIDS appear. This seems particularly true for women as the typical symptoms have been developed in a male population and do not include gynaecological symptoms among the typical lists.[9] High risk behaviours for contracting HIV include intravenous drug use, blood transfusion prior to 1985, practising homosexual or bisexual behaviour, multiple sexual partners and/or having sexual intercourse with a person who has HIV. Diagnosis of HIV or AIDS is dependent upon the individual's ability to discern their status, or upon a medical diagnosis based upon typical symptoms.

Typical physical symptoms of HIV include lymph node swelling of unknown origin, involuntary weight loss, unexplained fever over 38 celsius, chronic diarrhoea, weakness, fatigue, deteriorated ability to work, and night sweats. These symptoms can continue for several years before progressing to AIDS which is defined by the presence of AIDS specific diseases such as pneumocystis carinii pneumonia (PCP), cryptococcal meningitis, toxoplasmosis or various abnormal immunological laboratory test results.[10] In patients who have developed AIDS and died, the progression of the disease from infection to death has been about ten years. There are many opportunistic infections which characterize the early stages including thrush, shingles, severe athletes foot, and oral leukoplakia. As the helper cell count in the blood diminishes, there is a concurrent rise in the risk of life threatening opportunistic infections.

Psycho - Social Issues. The diagnosis of a terminal illness can trigger psycho-social problems in any person. There are, however, several complicating factors specific to HIV.

The three main points where persons with HIV are at risk for developing psycho-social problems are at the time of: (1) diagnosis of seropositivity; (2) the transition from asymptomatic to symptomatic; and (3) diagnosis of AIDS.

As Figure 2 indicates, the diagnosis of HIV in any of its forms may precipitate depression, suicide ideation, suicide attempts and suicide, and/or exacerbate any pre-existing mental illnesses.[11] The long incubation period and inability to predict when the infection will progress can leave the individual in a constant state of stress and uncertainty; physical decline and loss of attractiveness negatively affects self-esteem; the possibility of infecting others may result in self-imposed isolation and feelings of guilt; fear of reaction from lovers, friends, family, community and the workplace may result in an inability to seek appropriate forms of support. The experience of discrimination for many persons with HIV is not unusual if they have already identified with the gay community or are an injection drug user.[12]

FIGURE 2

The Psycho-Social Issues Associated with HIV Infection

Psycho-Social Issue
Uncertainty of Disease Progression
Loss of Some Physical Capacity
Loss of Some Sexual Capacity
Loss of Self-Esteem
Feelings of Guilt
Fear of Reaction from Community
Discrimination and Objectification
Self-imposed Isolation
Overwhelming Sense of Loss
Fear
Depression
Despair
Suicide

Discrimination escalates with a diagnosis of AIDS and previously supportive networks may disappear. In cases where homosexual behaviour has been closeted, the fear of being "found out" may create grave stress and anguish for the individual who fears being "out of the closet." Internalized homophobia, found to be common in gay men who are diagnosed as HIV positive and subsequently seek support, is seen as a response to long term negative social conditioning about homosexuality.[13]

About half of all HIV diagnosed persons in Canada are 30 to 39 years of age and about one quarter are 40 to 49 years of age. The combination of homosexuality and a diagnosis of a terminal illness in the prime of life makes it difficult for some individuals to resist the notion that it is a punishment rather than a disease that affects some people who have engaged in high risk behaviour. The new taboo is coming out of the closet as HIV positive, especially with other gay men.[14] Further, given that the vast majority of cases in Canada and the United States have affected gay men (85% in Canada), most gay men have friends who have died of AIDS. This personal experience arms the newly diagnosed individual with the knowledge of the intractability of the end, and an understanding of the losses that are yet to come.

For women the psycho-social issues related to HIV are often associated with their status as care givers in the family. Many women learn of their seropositive status at the time of pregnancy and are faced with the dual prospect of diminished capacity to care for themselves at the same time as the increased demands associated with the birth of a child. Women interviewed in this study expressed a severe sense of isolation, had fewer support networks than men, and admitted to disclosing their HIV status to fewer people than men who carry HIV typically do.

Hemophiliacs confront similar problems as other seropositive men. Given that hemophilia is genetic, many families experience HIV first through the extended family or hemophiliac community. Homophobia is an explicit issue for many men infected through blood transfusion. They are concerned that they will be identified as homosexuals because of their seropositive status. There is a strong association in the minds of most Canadians of HIV and homosexuality. In most communities outside of the three major cities in Canada, there is an avoidance by the hemophiliac community of the use of the word AIDS as a descriptor for an individual's condition.

For injection drug users the diagnosis of HIV can serve as a catalytic turning point and a decision to stop drug use. Diagnosis of HIV may offer an opportunity to begin the process of detoxification. This is not always the outcome of diagnosis, and if a change in illegal drug use does not take place then the progression from HIV to AIDS to death is accelerated.

The experience of HIV mixes both sex and death on the landscape of the psyche. These two primal forces in human existence are frightening to contemplate, thus a number of taboos to regulate public discussion have been created. The taboos, while serving the

needs of individuals in the community to deal with fear of birth and of death, operate to restrict open discussion and hence acceptance of persons infected with HIV. Fear becomes the operant response, of the individuals themselves and of the community toward the individual. The attendant consequences of actions/reactions based on fear are experienced by the individual in terms of psycho-social problems and then reinforced by the community response to the problems presented.

Fear for the future is a natural response, and stress coupled with uncertainty may further reduce the immunity of the individual. These factors may impinge on the individual's ability to cope with the disease and limit the support available within the community for similar reasons. It impinges on the ability of the individual to seek and access appropriate resources.

4. Housing Issues for Persons with HIV Infection

The presence of a terminal illness generally demands some change in housing situation. The diagnosis of AIDS is complicated by uncertainty in the progression of the disease, as not all persons will experience the symptoms while some persons experience many of them. Individuals can be very ill and then recover enough to resume previous patterns of living. The fact that the disease does not progress in a linear fashion means that the need for medical, social and support services is variable. Treatment regimes are dependent upon close monitoring of CD4 T cells and primary prophylactic action. Once a major opportunistic infection has occurred, then secondary prevention techniques are required. As none of the treatments thus far are cures, there is need for continuous interventions, many of which are administered in hospitals or specialized clinics. These factors affect the demand for housing around hospitals, specialized clinics or centres which serve the person with HIV.[15]

A report by the Resource Information Service of the London Special Needs Housing Group describes the standards for housing for persons with HIV infection as:

> *Their housing should be warm, easy to move around in and keep clean. It should offer privacy and control over their own lives. The effect of stress on their health means that their accommodation should be as stress free as possible. It should offer protection from harassment and physical attack, security of tenure and be manageable financially. Good housing is also housing that which is responsive to what people want, which offers them some choice about the way they wish to live and is flexible to changing circumstances. Housing for people with HIV needs to take into consideration the support and care they are likely to require if their condition worsens.*[16]

These criteria are offered as instruction to British housing planners who are attempting to respond to the social housing needs of persons with HIV infection. The situation for

most Canadians is much different in that, for the vast majority, housing is obtained in the private market, not through a non-market state subsidized sector. When searching for adequate, accessible, affordable and available housing, the person with HIV infection must consider their needs within the context of Canada's housing system. Unlike many European countries, the options in Canada are overwhelmingly constrained by the fact that 95 percent of the housing stock is in the private sector. Thus, Canada's system responds readily to effective market demand but not to social need.

Adequate Housing. Housing must be physically adequate. Canada has, on average, very high quality housing stock. The poorer quality stock tends to be concentrated in the private rental sector in the larger cities.

Housing for persons with HIV infection must be warm, dry, easy to keep clean and offer a safe, quiet and secure environment. While the list may seem obvious to every Canadian, the importance of warm, dry, mold free and simple to keep hygienically clean is of paramount importance to persons who are immuno-compromised. The risk of a cold or flu developing into PCP is significant. The presence of innocuous bacteria normally associated with food and sanitation facilities may prove deadly to a person who is HIV infected.

The community has an interest in the provision of physically adequate housing for persons who are HIV infected, especially for individuals who continue to engage in high risk behaviour. Of particular concern are homeless injection drug users. Without an address, they are more difficult to serve, monitor and provide ongoing prevention education. Similarly, without a place to sleep at night, it is more likely that the injection drug user will use drugs to stay awake and keep moving, thus further compromising their health.[17] Studies on safe sex practice indicate relapse to non-safe sex practices are fifty percent higher when drugs or alcohol are involved.[18] The epidemic rise of sexually transmitted diseases in inner city populations where sex is traded for drugs also gives rise to concern for the increased risk of HIV infection.[19]

In the case of the state's role in providing adequate housing, the issue may be framed in terms of social justice where the fundamental right to housing is not being met. Canada has taken no formal action to recognize or implement a right to housing. The Constitution Act, while providing for equal treatment before the law, does not enshrine economic or housing rights, and excludes protection from discrimination on the basis of sexual orientation.

Accessible Housing. Housing must not only be physically adequate, it must also be physically accessible. The entrance to the dwelling must be accessible for a person who is weak and in a state of chronic fatigue. A level entry or few stairs to climb are important to a person's ability to stay in their own home. A third floor walk-up cannot be considered accessible to a person carrying the day's groceries when they are already fatigued.

Inside the home, there must be room enough to allow a person who is physically handicapped to move about, and to move easily from bath, to bedroom, to eating area without significant impediments. The bathroom should have supports for access to the toilet and the bathtub.

Space for a care-giver to spend the night and/or move around the living area is important to being able to maintain the person in their own home during bouts of fatigue or opportunistic infections that do not require hospitalization, but require increased amounts of care. Many interviewees noted that a quiet location is an important factor in maintaining their health. Privacy is also important for both psychological and physical health reasons.

The problem of having physically accessible housing for persons who are HIV positive is further complicated by locational requirements. Housing must be reasonably close to the services required, such as shops and transportation, and medical and social services. Proximity to services has been a factor in demand for housing located near major hospitals. In Vancouver, the location of St. Paul's Hospital in city's West End coincides with a greater density of gay men than other areas of the city. This clustering of the gay community preceded the discovery of HIV infection. In Toronto and Montreal, there is a similar finding. Toronto's Casey House hostel and the group home called 127 Isabella are located in the College and Church Street area which is the centre of the gay community, and is also a centre for hospital services. In Montreal, Le Village is recognized as a gay area and Le Plateau as the anglophone gay area. Both are located in downtown Montreal. In Winnipeg there seems to be no one area where people who are HIV positive congregate despite the presence of the Village Clinic which offers integrated care and service for gay men and women, and particularly for persons with HIV.

The geographic distribution of Canadians with HIV infection is focused mainly in the three largest metropolitan areas, Toronto, Montreal and Vancouver. HIV infection, in terms of locational distribution of the affected population, is mostly an urban phenomenon. This finding is most likely skewed by the fact that many persons who suspect that they are HIV positive go to the major centres for testing. Epidemiological data related to seroprevalence are collected on the basis of the diagnosis site, not the person's residence.

There appear to be advantages for individuals with HIV if they live close to one of the big three medical and social service centres. The community organizations which respond to the needs of persons with HIV are more accessible, and additional support is often available on the basis of the person's close proximity to this community of interest. In many cases service delivery is more efficient as there are shorter distances to be covered for both the care-giver and the person seeking care. A critical mass of people concerned about the impact of HIV on people is formed and the necessary energy to develop services can be channelled productively.

Government support for an integrated services centre is, at first glance, more efficient by concentrating resources and expertise in a single location. The competing scenario is that of ghettoizing the population of interest into a particular geographic location. Further, by situating services in a single location, those persons who do not live in the immediate vicinity are under-served. Persons with HIV in rural areas have little or no support system and even those persons who reside outside of the big three metropolitan areas find that they do not receive the same calibre of service. For example, in Victoria, persons with HIV outside of hospital must go to Vancouver to have a blood test. In Regina, there is one health care professional who is designated as responsible for the HIV population.

Affordable Housing. "Most Canadians who are disabled are poor."[20] In studies of the homeless, a strong correlation has been observed between the onset of a disabling condition and the subsequent transition to homelessness.[21] The facts related to income distribution support this observation in the context of persons with HIV. Single adult earners are in a poor position compared to dual earner families and are at a higher risk for sinking below the poverty line than almost all other groups with the exception of single parent women.[22] Many women with HIV infection have children and are thus at a very high risk of being in poverty.

Among the HIV infected population in Canada, the exception is the group who have benefitted from the federal government's Catastrophic Relief Program. This program pays $120,000 cash over four years to persons who contracted HIV as a consequence of blood transfusion prior to 1985. Approximately 943 persons have applied for benefits under the Catastrophic Relief Program, the overwhelming majority of whom are hemophiliacs.

Others with HIV face an accelerated decline into poverty as they are forced to leave their jobs due to illness. For those able to maintain their attachment to the labour force, the attachment becomes more like a shackle than a voluntary association because many are afraid to move jobs for fear of being uncovered as seropositive as a consequence of medical tests required for life insurance; or they realistically fear that the added stress of taking on a new job may imperil health.

Given that the average age of persons with HIV infection is between 30 and 39 years, most have not built up significant savings. Also, as the most frequently reported risk for persons with HIV in Canada is through homosexual contact, the majority are not in a relationship that resembles marriage as an economic union. Single men in their mid-thirties who are identified as homosexuals are prone to be stigmatized as they do not fit within the cultural norm of "deserving poor," despite the fact that they are indeed sick and in need of financial support. Therefore, the experience of many interviewees is one of having to persistently fight for any or all entitlements provided by the state. Income assistance is stigmatizing for most recipients, but being single, male, mid-thirties and gay is a combination that is destined to ascribe marginality in our culture, unless there is significant political activism by supportive members of the community.

The situation for women with HIV, especially those with children, is very difficult financially. While they may receive income assistance, it is usually insufficient to meet both shelter and support needs. Mothers on income assistance who are also HIV positive may be unable physically to access free services such as food banks to supplement their inadequate incomes.

Injection drug users when faced with spending money on housing or drugs to support their habit will satisfy short term needs. Housing affordability as an issue for injection drug users is experienced more at the level of the community of interest, who are trying to provide appropriate housing at a price that is within reach of the agencies concerned.

Whoever the constituency, there is an obvious gap between income substitutes and the poverty line, whether the money comes from disability pensions or income assistance. The lack of adequate core income programs condemns most disabled persons to live in abject poverty.

Both the community of interest and the geographic community have a concern in affordable housing for persons with HIV. The community of interest may be those persons who are active advocates on behalf of persons with HIV and include seropositive members. The geographic community, who are the majority, are the neighbours in the community where persons with HIV live, and in particular the residents of Toronto, Montreal and Vancouver. There is pressure not to raise taxes to pay for services for persons with HIV by rate payers. Similarly, the local population does not want to have its local hospital beds filled with persons who are there because there are inadequate housing options. In short, there are competing interests within the community.

The government position with respect to housing affordability issues and HIV infection is related to revenue transfers between the three levels of government. Who pays how much and for what is a complicated issue because housing in Canada is left primarily to the private sector. There is very little control over housing markets, especially rental housing, other than different provincial regulations. The attempts to address the housing affordability problems for urban poor in Canada have been inadequate and little progress is being made.[23] There is even less effort to address the housing needs of newer special needs groups such as persons with HIV, other than the recipients of Catastrophic Relief payments who are a very small proportion of the persons with HIV.

Available Housing. Housing availability is closely related to the other three aspects of housing issues. Appropriate, accessible and affordable housing must be available in locations where it is needed. Canada's housing system has no problem producing the higher cost ownership and rental housing options. The problem is making available enough appropriate, accessible and affordable housing where it is required.

Many HIV positive individuals choose to live close to the health and social service centres which put them into higher priced neighbourhoods than they might otherwise choose. The

urban core, which is the site of the largest medical service centres in Toronto, Montreal and Vancouver, means that the person with HIV is competing in rental markets characterized by persistently low vacancy rates which severely limits the options available. Table 1 provides a summary of the vacancy rates for the larger metropolitan areas for a recent four year period. In Toronto and Vancouver the vacancy rates have continually been at or well below one percent. In Montreal the vacancy rates are generally higher, however, the income assistance rates in Quebec are the among the lowest in Canada.

With the exception of persons with hemophilia, the majority of persons we interviewed with HIV were not homeowners. Homeowners who loose their source of income must struggle to maintain themselves in their own home, while renters must seek appropriate accommodation in the private rental sector which has few available options.

TABLE 1

Rental Housing Vacancy Rates in the Larger Metropolitan Areas Canada, 1987 - 1989

	1987	1988	1989	1990
Toronto	0.1%	0.2%	0.3%	0.8
Montreal	3.6%	4.0%	4.9%	5.3
Vancouver	1.1%	0.4%	0.4%	0.9
Average for 25 largest Metropolitan Areas	2.5%	2.6%	2.8%	3.3%

Source: Canada Mortgage and Housing Corporation (1991) *Canadian Housing Statistics 1990*, Ottawa: CMHC, Table 29. Vacancy rates based on CMHC bi-annual surveys of private sector rental apartment buildings with six or more units.

Two out five households in Canada are renters and they concentrate in the three largest cities, where fully 60% of all households are renters.[24] The National Council of Welfare estimates that approximately 37 percent of renters live below the poverty line compared to less than 10 percent of homeowners.[25] Availability of rental accommodation for persons with HIV is constrained by competition on the open market where vacancy rates do not rise above three percent; the need for accessible housing as previously defined; and the most desirable locations limited to certain neighbourhoods in each of the three largest cities. The aggregate vacancy rates do not take into account the actual vacancy rates in the rental units in the bottom one-third of the price range, the

part of the rental market which is under considerably greater pressure than the overall rental market. This observation is underscored by the recent report on distribution of incomes by Statistics Canada which finds that among renters, rent consumed at least 30% of income for more than one-quarter of families while for the lowest-income families almost 55% of income went on rent.[26] This is the situation for persons who wish to remain and are able to maintain themselves in their own household.

The availability of financial support for other than independent living is constrained by lack of resources appropriate to the needs of persons with HIV. There are across Canada limited resources for home-care support, group care residence, congregate care such as the planned Helmcken House in Vancouver, and for existing facilities such as Casey House in Toronto, Les Habitations Jean-Pierre-Valiquette in Montreal, and Karos House in Edmonton. Other cities such as Winnipeg are at the needs assessment phase in planning for residences. Hospital beds across the country are under pressure, and the lack of available resources for persons being discharged from hospital means that persons with AIDS may be in hospital longer than is desirable. Palliative care beds in the hospital are used for persons with AIDS in the final stage. It has been noted by several health care professionals, however, that due to the lack of available housing in the community, it appears that persons with AIDS have longer stays in palliative care units than other patients. Hospices are another choice, and appear to be appropriate for some persons. The issue for the majority of hospices is the lack of adequate core funding to accomplish the task of supporting people to the end of their lives.

The community has an interest in ensuring that there are various housing services available to meet the needs of persons with HIV infection over the course of their disease. If there are inadequate services to support individuals who are in the chronic stages of the disease, then the alternatives are to utilize acute care services which are generally more costly. For the community of interest, the family or supportive network involved with individuals with HIV, there is a burden of care associated with a lack of service. If the only choices are living at home or hospital care, then the supportive family or friends may be unable to provide the level of support required to meet the physical and emotional demands of a person who has HIV on an ongoing basis without respite care and/or other support services. The geographic community may counter any proposals with NIMBY (not in my backyard) attitudes which have created dilemmas for many residential services, whether they are HIV related or not. Communication with the neighbourhood and involvement of key persons of influence in the community are essential steps in order to make the community neutral at least towards the idea of housing.

The state role is complicated by the nature of the bureaucratic organization of the services required for the person with HIV. Persons with HIV require health care, social services and housing support, services which are not provided under one integrated Ministry in any province. The issue is further complicated by the nature of the distribution of jurisdiction -- thus responsibility -- for each of these issues to the federal, provincial and municipal levels of government.

There is no uniform pattern of service delivery or locus of responsibility for services to person who are HIV infected in Canada. By virtue of Canada's constitution, responsibility for housing, social services and health care services are provincial responsibilities. The logic of distribution within each province is, for the most part, idiosyncratic and related to the historical development of services in each individual province. Availability of services and the nature of the system of service delivery is provincial and decided upon individually.

The role of the federal government has been to stimulate and initiate the development of new services and service forms, not to provide ongoing support for operational costs in what is seen as a provincial responsibility. The three major cities, Toronto, Montreal and Vancouver, have all pledged municipal support for addressing some aspect of the service needs of persons with HIV. They are not required to do this, but are responding to local political pressure to help out. The federal government, starting in the mid-1980s, has further worsened the housing situation of lower income and special needs groups in Canada by continually reducing the number of new subsidized housing units built each year.[27] In general, the political will to act on this issue seems to be clearly lacking at all levels of government in Canada.

5. Housing Options for Persons with HIV Infection

There can be no one definition of "appropriate" housing. It is housing that is suitable to the individual and depends upon the individual's specific needs. It maximizes choice, independence, and a sense of belonging to the community. True choice means that services must be available that are appropriate to the person's particular situation. Housing, as a physical structure, and the social support services required by an individual or a family, cannot be considered separately. Thus, if the desired state is to maintain the individual in his or her own home, what are the services that are required to facilitate that choice? These issues are particularly difficult for persons with HIV, whose health status and level of physical and mental competency is subject to continual change. Housing related support needs change as the disease progresses. Just as there is a continuum between independence and dependence, there must be a continuum of care linked to appropriate housing for the person with HIV. As this disease does not have an orderly linear progression, the continuum of care must be flexible and responsive to the changing needs of the individual.

Housing has an integral role in both health protection and health promotion. For persons with HIV infection both health protection and promotion strategies are needed in order to prevent further transmission of the disease. Prevention is associated with being able to provide security, and security is related to being housed where one can have a permanent address. Housing is the anchor from which one locates oneself in the community, receives and accesses services, and exercises basic citizenship rights. Health promotion approaches view health as a resource for control over one's life, and meeting

basic needs, such as appropriate housing, is essential to effective health promotion. Preventing further spread of the disease is dependent upon lifestyle changes that everyone has to make. Preventing rapid transition from seropositivity to AIDS is dependent upon adopting healthy lifestyle choices that are designed to promote wellness, reduce stress, and increase supportive contacts within the community.

There are competing forces that must be considered in the provision of appropriate housing for persons with HIV infection in Canada. The individual's health status, the culture in which we live and the political, economic and social contexts are important factors in planning for the immediate and future needs for persons with HIV. Action to solve the problem must be based in a clearly defined set of values and principles that address the rights and needs and the individual with HIV, support the community in meeting the needs and honouring the rights of the individual. Finally, government must enact programs and policies which respect the rights and responsibilities of individuals in the community to achieve health for all.

As outlined in Figure 3, the continuum of housing options is based on the physical and mental competency of the individual, that is, on the individual's level of ability to exercise choice. Self care requires a high level of competency and does not require any special form of housing. It does require that the housing system make available a full range of appropriate options which are adequate, accessible and affordable. Since most people with AIDS and many with HIV are concentrated in the central areas of Canada's three largest metropolitan areas, Canada's housing system is not able to provide appropriate housing for those who need it. In addition, there is the problem of discrimination in the private sector housing market and the small size of Canada's subsidized non-market housing sector.[28] Adequate, accessible and affordable housing is often not available where and when it is needed for persons with HIV infection.

For persons with reduced competency a higher level of care is required. Group homes, extended care facilities and specialized hospices provide the range of care required, though there are presently few such options available in Canada. In addition, there is the problem of locating these special housing options. Neighbours (often entire neighbourhoods) actively oppose the location of a group home or hospice. For those who have minimal competency in exercising choice, and who do not want or cannot find room in an hospice, there is no choice but the hospital.

FIGURE 3

Housing Options for Persons with HIV Infection Related to the Individual's Abilities and the Level of Care Required

Levels of Ability for the Individual to Exercise Choice	Levels of Care	Type of Housing
Most Able	**SELF CARE** • **Individual (no support)** • **Supported** • **Family Support** • **Foster Care**	The *self care* options usually take place in single and semi-detached houses and in condominium or rental apartments. The nature of the local housing market (vacancy rate, housing adequacy, availability and affordability) is one important factor. Other factors include access to medical and support services.
Less Able	**GROUP CARE** • **Group Homes** • **Extended Care Facilities** • **Hospice**	The *group care* options require the conversion of an existing house or small building, or the construction of a purpose-built facility. Purpose built buildings are not part of the regular housing stock due to their specialized features. Without this form of housing available in a community, there is no intermediate support between self care options and hospitalization, the most expensive form of care.
Least Able	**HOSPITAL** • **General Ward** • **Palliative Ward**	These options do not require housing stock. The person is out of the housing stock and in a specialized institution (the hospital).

6. Conclusion: Housing System Change

Housing for persons with HIV in Canada poses serious questions about how society and its institutions respond to the most marginalized people. The ability of persons with HIV to obtain appropriate housing is an excellent surrogate indicator of the health of our communities, if we define a healthy community as one in which all organizations from informal groups to governments are working effectively together to improve the quality of all people's lives. A healthy community is an organizational ideal based on values of self-governance, proactivity, mutual respect and creative conflict resolution. The emergence of HIV provides a test of how healthy our communities are and a test of how well we respond to the need for change, including change in our housing system.[29]

For persons with HIV, and for those with AIDS in particular, there is very little elasticity of demand for adequate accessible housing. They have a limited ability to make trade-offs between the quality of the accommodation, its location, and the price (rent) paid. In tight rental markets, where low vacancy rates mean high prices and limited availability, which is especially the case in Toronto and Vancouver, persons with HIV can pay more than half their income on housing. They must have clean and accessible housing in a location convenient to the services they require. Finding adequate accessible housing can also be a problem for persons with HIV in smaller towns and rural areas, where there are fewer housing options meaning very limited choice.

Of the five HIV constituencies examined -- homosexual men, hemophiliacs, women with HIV, injection drug users, and sex trade workers -- only one group, hemophiliacs, reported having few housing related problems.

For homosexual men who are HIV positive, the diagnosis of HIV is often followed by a decent into poverty. This decent is accelerated in major urban centres. The cost of meeting their health and psychosocial needs is also very high. For those HIV positive males in smaller cities and towns in Canada, the lack of accessible medical and social support services eventually draws these persons to the larger urban centres where they too must face the high cost of appropriate housing.

For women with HIV, the issue of poverty is compounded if they are parents. Canada has a poor record with respect to addressing the needs of families with children and single parent families living in poverty. Six out ten children of single parent mothers live below the poverty line. The record is even worse for disabled women where it is estimated that more than three-quarters live below the poverty line.[30] The combination of these two factors means that mothers with HIV are forced to make detrimental trade-offs to satisfy their individual health needs and the immediate health needs of their children. Mothers with HIV choose residential locations that are close to schools and appropriate to family life rather than close to inner-city clinics or hospitals that offer the appropriate medical care.

Injection drug users' need for appropriate housing is complicated by their need for drugs. Money to satisfy housing needs will be used instead to satisfy drug needs. As a consequence, injection drug users who are HIV positive are the group most likely to be homeless. The services that are designed to serve the majority of persons with HIV are inappropriate for injection drug users who have different cultural norms. Service providers involved in housing provision for injection drug users recognize that, for most of this population, middle class white institutions are unable to adequately address or even cope with the intensive needs of injection drug users and the high degree of autonomy demanded by this group. According to standard definitions, injection drug users are "non-compliant patients" and, as a consequence, are often unable to procure the necessary health and social services unless these services are specifically adapted to meet the needs of this constituency.

Sex-Trade workers are not a homogenous group. Housing needs will depend upon the group that they most closely identify with, such as, women with HIV, injection drug users, homosexual men, or others. The housing needs of this mixed group depend upon the specific individual and it is difficult, perhaps impossible, to generalize.

In all constituencies examined there was little difference in the elasticity of demand for housing that was adequate and accessible. Drug users, however, place a higher priority on satisfying their immediate need for drugs than the need for housing. This exception relates to a minority of the population of persons in Canada who are HIV positive. For the majority of HIV infected Canadians the problem of the price paid for housing goes beyond the dollar amount paid, but includes the price paid in reduced choices and undesirable trade-offs made relating to housing.

Intervention in the supply of housing to increase and/or maintain appropriate housing for persons with HIV must begin with identifying which aspect of appropriate housing is missing. Is the housing stock inadequate? Are support services available to help people to remain in their own homes? Is housing affordability a problem? Are vacancy rates low? The second step in identifying the problem is recognizing that persons with HIV who live in poverty have to compromise housing quality and location in exchange for housing which is affordable and available. The need for safe, clean, accessible housing with close proximity to medical and support services is not an optional requirement without severely compromising health status thus reducing life expectancy and quality of life remaining.

If persons with HIV are to obtain appropriate housing, aspects of Canada's housing system will have to change. Figure 4 provides a model of the possible range of housing system changes. There are four broad categories of actors (institutions) capable of addressing the housing needs of persons with HIV or, for that matter, any group or individual in need of housing assistance. The state, the private market, community organizations, and individuals and families can take action to address the housing needs

of individuals with HIV, or any of the specific groups with HIV, or for the entire population of persons with HIV.

FIGURE 4

Points of Intervention For Housing System Change

Category of Need	Institution			
	State	Private Market	Community	Individuals and families
Needs of Individuals with HIV				
Needs of Specific Groups with HIV				
Needs of All Persons with HIV				

Since 95% of Canada's housing stock is in the private sector (about 40% of which is private rental and the remaining 60% owner occupied), the locus of the housing problem is with the market provision of housing, in particular the lack of affordable rental housing in the larger cities. The socially assisted non-market sector is very small and is already incapable of meeting existing severe housing needs, let alone the new needs of persons with HIV. State intervention, community based activity, and increased support from individuals and families, are the three areas where solutions will have to originate.

A further role for federal, provincial and municipal governments is inevitable. The state must use a combination of its available methods, which range from exhortation and moral

suasion, to direct expenditures, tax expenditures, taxation, regulation, and public provision/ownership. The state can provide resources to community based non-profit associations and agencies, forms of assistance can be provided to individuals and families, and regulations, taxes or subsidies can be used as incentives for appropriate private sector activity.

In light of the recent health promotion policy initiatives of the Federal government (and the support these receive at the provincial level), it is surprising that more has not yet been done around the issue of housing for persons with HIV. Health promotion is defined by the federal government as "the process of enabling people to increase control over and improve their health," a definition taken from the World Health Organization and enshrined in the Ottawa Charter for Health Promotion.[31] Embodied within the concept of health promotion are notions of social justice and equity, and social responsibility to allow people to fulfil their aspirations. If health is, in fact, a resource for daily living, then persons with HIV must be supported through fair and flexible housing policies that enable them to maintain control over and improve their health.

Failure on the part of the government to respond to this issue will render meaningless the Framework for Health Promotion and increase the growing sense of cynicism that Canadians feel toward the state.

The problems persons with HIV are having obtaining appropriate housing will only be resolved by changing some elements of Canada's housing system. Though the problem is directly connected to poverty and inadequate income, there simply is not enough appropriate housing stock available in the locations where it is required. Because of the relatively high status the HIV/AIDS issue has on the public agenda there is some reason for being optimistic that there is enough political will being generated to result in some action to address the housing needs of persons with HIV.

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